

**Investigation into the circumstances surrounding the
death of a man at HMP Pentonville
in April 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

March 2009

This is the report of an investigation into the death of a man at HMP Pentonville in April 2008. He was found suspended by a ligature in his cell in D Wing. A post mortem examination carried out the same day confirmed the cause of death as hanging.

I offer my sincere sympathy and condolences to the man's family and friends for their tragic loss.

The investigation was conducted by an investigator.

I also commissioned a clinical review of the management of the man's health needs while he was in custody. This was conducted by a clinical reviewer on behalf of the local Primary Care Trust. I should like to thank her for her invaluable contribution to the investigation.

My thanks also go to the Governor and his staff at Pentonville for their help and co-operation during the investigation. I pay particular tribute to the liaison officer for his help.

On 1 May, one of the Family Liaison team made contact with the man's mother over the telephone to enquire as to whether any family members wished to meet her and the investigator to express any matters of concern about her son's time in prison and his death at Pentonville. She explained that she and her husband were too distressed to speak to anyone at that stage. My heart reaches out to them: there is surely no worse pain that parents can suffer than that caused by the loss of their child. The family liaison officer later wrote to them to reinforce that that she would be more than happy to hear from them if they changed their minds. Although no further contact was made, this report will be sent to them.

My report is critical of some aspects of the use of the suicide and self-harm monitoring forms for the man. The clinical review draws attention to a number of deficiencies in the management of his mental health and of his drug misuse.

The Ombudsman's office has investigated a number of previous self-inflicted deaths at Pentonville. As with some of those cases, I make recommendations in this report about ACCT procedures and about healthcare issues.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Deputy Ombudsman
2009

March

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SUMMARY

The man had a history of dependency on alcohol, poly-substance misuse and possible personality disorder. He was well known to the Mental Health services, having had numerous admissions as a psychiatric inpatient up to and during 2004, with one subsequent admission in 2007.

He was remanded into custody at HMP Pentonville for a week in August 2007, during which period he received opiate and alcohol detoxification. Following a breach of bail, he was remanded again on 6 November 2007. He was taken to HMP Wormwood Scrubs that day. Upon his arrival, he was not considered to be at risk of self-harm. On 8 November, following an appearance at Crown Court, he was taken to Pentonville. During his time in the custody of the staff who escorted him between the court and the prison, he said he was withdrawing from drugs and would kill himself if he did not get the drugs he wanted. A suicide warning form was completed to alert prison staff to this risk. The form was not signed by anyone at Pentonville. Although he was assessed by a nurse and a doctor soon after his arrival, his records do not make clear whether his risk of self-harm or suicide was considered.

During his time at Pentonville, the man once again required alcohol detoxification. He was under the care of the Mental Health in-reach team and was admitted to the healthcare centre on three occasions. On one occasion, he was taken to hospital after experiencing hypotension. He was discharged the same day.

On 20 December, an Assessment, Care in Custody and Teamwork (ACCT) form was opened after the man deliberately cut his arm. This form is used by the Prison Service to monitor and support those prisoners considered to be at risk of self-harm or suicide. The form was closed on 7 February and re-opened two days later after a further minor act of self-harm. There was no evidence to show whether any case reviews were conducted thereafter or whether this form was closed.

In January, he made voluntary contact with the Counselling, Assessment, Referral, Advice and Throughcare service (CARATs). Despite this positive development, there were unsubstantiated reports that he continued to use illicit drugs.

After he threatened to hang himself on 12 March, he was admitted to the healthcare centre and a new ACCT form was opened. This was his last admission and the final occasion on which an ACCT form was used. A psychiatrist who saw him nine days later considered that he could be discharged to a wing but needed "the highest level of observation" in a shared cell and said that the ACCT form was to remain in place. He was discharged on 21 March. The psychiatrist arranged for him to be reviewed again a week later. However he was not assessed again.

On 1 April, the man was taken to hospital after apparently experiencing an episode of hypotension. He was discharged to the prison the same day. Five

days later an ACCT review panel met to consider his current risk of self-harm. He was thought to be well balanced with no concerns. He was getting on well with his cellmate. His risk was judged to be low.

A few days later, the man's cellmate left the cell to talk to friends on another landing, leaving him alone. Shortly afterwards, he left his cell to telephone his girlfriend. She was extremely angry with him for allegedly lying to her about the length of sentence he was likely to receive at a pending court hearing. She told him she did not love him any more. He returned to his cell. An officer who saw him thought he appeared to be alright. At 3.40pm, he was found hanging in his cell. The determined attempts by healthcare and discipline staff and by the paramedics to save his life were unsuccessful. He was pronounced dead at 4.26pm.

My report is critical of some aspects of the ACCT procedures. I question the wisdom of discharging the man from the healthcare centre on 21 March when his risk was such that he was considered to require the highest level of observation in the wing. I express my concern at the fact that he was left alone in his cell on the day of his death, despite the fact that he was on an open ACCT form. The clinical reviewer draws attention to a number of deficiencies in the standard of mental healthcare offered to him.

However, I commend those staff who were involved in the discovery of the man hanging and in the attempts to save his life in very harrowing circumstances. I make special mention of one member of staff who gave mouth-to-mouth resuscitation without a protective face mask regardless of the risk to his own health.

The clinical reviewer and I make a range of recommendations that I hope will reduce the risk of a similar tragedy occurring at Pentonville or elsewhere in the Prison Service.

INVESTIGATION PROCESS

1. The investigation was opened on 14 April 2008 when an investigator met the Governor, Deputy Governor, a member of the Independent Monitoring Board and the secretary of the local branch of the Prison Officers' Association. He briefed the meeting on the terms of reference for the investigation. On the same day, notices were issued to staff and prisoners announcing the investigation and inviting anyone with information or concerns relating to the man's death to make themselves known. Three prisoners came forward.
2. The investigator also commissioned a clinical review of the management of the man's health needs while he was in custody. This was conducted by a clinical reviewer on behalf of the local Primary Care Trust. Shortly after the man's death, an internal review of the quality of medical and nursing care given to him was conducted at Pentonville in order to identify any lessons that could be learned and to implement any necessary improvements. It is much to Pentonville's credit that such a prompt and thorough review was carried out. In conducting her independent clinical review, the reviewer took account of the findings of the internal report.
3. Nine members of staff and two prisoners were interviewed during the course of the investigation.
4. On 1 May 2008, one of the Family Liaison team contacted the man's parents to ascertain whether they wished to express any concerns for the investigation to address. They chose not to become engaged with the investigation at that stage. However, they will be given an opportunity to receive the draft report and can decide to become involved with the investigation at any stage.

HMP PENTONVILLE

5. Pentonville is a local prison serving courts in north east London. At the time of the investigation, it could hold up to 1152 prisoners. The accommodation comprises the following seven units:

- A wing - First Night Centre
- B,C,D and G wings - hold convicted and remanded prisoners
- G wing – holds convicted and remanded prisoners with enhanced privilege status
- E wing - Detoxification Unit
- Segregation Unit
- Vulnerable Prisoner Unit (VPU)
- Healthcare centre
- R wing which is currently closed.

6. Healthcare at Pentonville is provided by the local Primary Care Trust. The healthcare centre has beds for up to 22 inpatients.
7. The establishment was last inspected by Her Majesty's Chief Inspector of Prisons in June 2006. In her report of that inspection, the Chief Inspector pointed to improvements in some areas since her previous visit in 2005. However, she reported that throughout her prisoner survey, responses to most questions were significantly worse than the comparator for other locals.
8. Where safer custody was concerned she wrote,

“Last time, we had a particular concern about the support of prisoners in the early days of custody: especially as five out of six recent deaths had taken place within days of arrival. Though the physical environment for first night prisoners had improved somewhat, the arrangements to support them did not work effectively, and more prisoners than in 2005 said they felt unsafe on their first night. This important area was outside the remit of the new safer custody arrangements.”

9. In the concluding paragraphs of her report, she said,

“We do not underestimate the problems faced by managers at Pentonville. Its population, always transitory, had become even more so with a 10 per cent increase in remanded and unsentenced prisoners, who accounted for over 60 per cent of the population. Overcrowding, old buildings and inadequate facilities severely inhibited the prison's ability to deliver a safe, decent and purposeful environment for its prisoners.”

10. In the executive summary of their annual report for the period 1 April 2006 to 31 March 2007, the Independent Monitoring Board at Pentonville wrote as follows:

“It has again been a difficult year for Pentonville Prison. The unprecedented national pressure on prison places was reflected in conditions at local level. We have seen staff struggling to cope daily demands of managing a virtually full to operational capacity prison with no real opportunity to devote time or energy to longer term objectives.”

11. The Board pointed to some positive aspects of the establishment's operation as well as to some shortcomings. Their report drew attention to the fact that there had been no self inflicted deaths in the prison during the year. They believed this reflected the increasing priority given to safer custody. However, the Board said there was no room for complacency. There were two areas that stood out as sources of serious risk: the poor reception facilities and the continuing problems with cell bells being unanswered. The Board also recorded that there had been 393 acts of self-harm, of which 58 were attempts at hanging. They also reported that 643 ACCT documents had been opened during the year.

12. Where reception facilities were concerned, the Board wrote,

“We are greatly concerned about the inadequacy of the reception facilities. Pentonville has a high level of receptions and discharges and the building now in use for these purposes is quite simply not large enough, nor is it sufficiently well equipped. This is a critical function for the prison. If the reception of new prisoners is not dealt with properly there are adverse implications for the entire regime. In particular there will be a serious danger that prisoners at risk of self-harm are not identified.”

KEY EVENTS

Background

13. The man was remanded in custody at HMP Pentonville on 13 August 2007 on a charge of criminal damage. He was identified as having a history of poly-substance misuse, requiring an alcohol and opiate detoxification, of low mood and at risk of self-harm. He had been admitted to a psychiatric hospital on several occasions, the most recent of which was in 2004.
14. During that brief period in custody at Pentonville, he was referred non-urgently to the mental health in-reach team and to the substance misuse service. He was transferred to the substance misuse unit the day after his reception and assessed by a doctor. His alcohol detoxification continued and a methadone detoxification programme was commenced.
15. After a week, the man was released on bail. However, on 4 November, he was arrested for breaching his bail conditions. He was kept in police cells overnight.
16. The next day, he was taken to a Magistrates Court. At about 1.30pm, whilst in court cells, he was examined by a doctor who recorded his findings as follows:

“Complains of shakes. Feeling anxious and sweating - alcohol withdrawal symptoms. Has been given valium in police cells. Drinks a bottle of vodka daily. History of alcohol withdrawal seizures. No known allergies. Not on any regular medications. Stable. Alert. Undistressed. Orientated. Plan: 10mg valium, monitor regularly.”
17. Another doctor saw the man at 9.00pm that day. The doctor too noted that he was experiencing shakes and prescribed Diazepam. The doctor assessed him as being fit to be transported by cellular vehicle.
18. The magistrates remanded him in custody and ordered him to appear at Crown Court on 8 November. He was taken to HMP Wormwood Scrubs.

HMP Wormwood Scrubs: 6-8 November 2007

19. When the man arrived at Wormwood Scrubs, he told reception staff he was born on 27 February 1970 and was single and unemployed. He said he had been living at an address prior to his arrest. He confirmed that his father was his next of kin and disclosed his address.

First reception health screen

20. As soon as a prisoner arrives in a prison he should undergo a first reception health screen and a cell sharing risk assessment. The purpose of the health screen is to enable medical staff to establish what the prisoner's immediate physical and mental health needs are so that appropriate action can be taken to meet those needs.
21. The purpose of the cell sharing risk assessment is to assess the risk a prisoner presents of harming another prisoner if he shares a cell. This has to be balanced against his risk of harming himself if he is placed in a cell on his own. The assessment is normally undertaken by a prison officer as well as a nurse.
22. During the first reception health screen, conducted by a nurse, the man said he had a doctor in the community and disclosed the doctor's name and surgery address. However, he said he had not seen a doctor during the previous few months. He said he had no outstanding medical appointments of any kind. He disclosed that he had been taking Diazepam 5mg (for relief of anxiety) each day and Olanzapine 10mg (an anti-psychotic drug) each morning. He had not received any physical injuries in the previous few days. Although he did not suffer from asthma, diabetes, tuberculosis, sickle cell disease or any allergies, he claimed to have experienced an epileptic fit as recently as the previous evening. He also said he was experiencing some chest discomfort.
23. The man told the nurse he was used to drinking a bottle of vodka and ten strong lagers daily but claimed he had not had any alcohol for two days. He also admitted he had used amphetamines during the previous week.
24. As far as his mental health was concerned, he disclosed that he had received psychiatric treatment four weeks earlier, specifying that he had been an inpatient at a psychiatric hospital in. However, he said he did not have a psychiatric nurse or care worker in the community. He repeated that he had been prescribed Olanzapine.
25. The man said he had tried to harm himself outside prison, claiming to have run in front of a car six months earlier. The nurse was required to ask him if he currently felt suicidal now that he was in prison. He wrote,

"Withdrawing from alcohol abuse, evidence of withdrawal. States suffers from depression. States mood is low but denies any self-harm thoughts or suicidal intentions."
26. Although the nurse did not make clear whether the man wished to consult a doctor, he did record that a referral was made for him to be assessed by a doctor because of his alcohol abuse. He was not

screened for drugs but an alcohol detoxification programme was commenced.

General health assessment

27. The man underwent a general health assessment the next day. His height was recorded as 172cm and his weight 84.7kg. He said he smoked but wanted to give it up. He said there were no illnesses in his family. No matters of particular concern arose during this assessment.

Cell sharing risk assessment

28. An officer conducted the cell-sharing risk assessment. The following table shows the questions asked of the man and the answers he gave:

Questions	Answers
Have you ever abused alcohol or drugs?	Yes
Are you currently dependent on drugs or alcohol?	Yes
Are you subject to a current ACCT form?	No
Have you been subject to an ACCT form in the past?	Yes
Do you have any concerns about sharing a cell?	No
Would you describe yourself as a person that gets angry or frustrated quickly?	No

29. The officer made a separate note of the fact that the man had told him he was dependent on alcohol and suffered from depression.
30. The nurse completed the healthcare element of the assessment and confirmed that no concerns had emerged about any risk of self-harm. The man was assessed as presenting a low risk of harming others and was therefore deemed suitable for sharing a cell. This conclusion was countersigned by a manager.
31. He was taken to the First Night Centre where no events of any significance were recorded.

Court appearance and transfer to HMP Pentonville

32. On 8 November, the man was taken from Wormwood Scrubs to Crown Court, where he was once again remanded in custody. The Prisoner Escort Record (PER) for the journey from the prison to the court carried no notation of any risk of self-harm or suicide but did mention that he had a "mental condition". After his court appearance, he was transferred to HMP Pentonville as this is the local prison in London which serves the Crown Court.
33. During his time in the custody of the escorting staff, the man told a Senior Prisoner Custody Officer (SPCO) that he was withdrawing from drugs. He said that if he did not get his drugs, he would kill himself. The SPCO therefore raised a suicide/self-harm warning form. The purpose of this form is to draw the attention of prison staff to any risk of

self-harm or suicide so that appropriate steps can be taken to monitor and manage that risk. The form should be signed by reception staff as soon as the prisoner arrives in a prison. His warning form was not signed upon his arrival at Pentonville.

HMP Pentonville: 8 November 2007 - 9 April 2008

November

34. The man was seen by a nurse and a doctor upon his arrival in reception at Pentonville on 8 November. He told staff he had been a psychiatric inpatient with a possible severe mental illness. He complained of auditory hallucinations. As a result, an urgent referral was made to the Mental Health in-reach team. Receipt of this referral was not documented until 14 November, six days after it was made. His alcohol detoxification was continued. However, he was not screened for drugs. There is no notation in his records showing whether his risk of self-harm or suicide was assessed and no ACCT form was opened.

Admission to the healthcare centre

35. Three days after his arrival at Pentonville, staff became concerned that the man seemed to be suffering from hallucinations. They therefore asked for him to be assessed by a member of the healthcare team. The nurse who saw him decided to admit him to the healthcare centre as an inpatient.

Mental health review by a doctor

36. On the day following his admission to the healthcare centre, the man was assessed by a doctor, who wrote as follows in his medical record:

“Patient interviewed on healthcare (E Wing). Was admitted over the weekend due to experiencing distressing hallucinations. Was initially on A Wing – required alcohol detox following admission 3 -4 days ago. Not clear why he was not on detox wing. Admits to using at least 8 cans of strong cider/day and has dependence syndrome - begins drinking in the morning. Also claims that has been self-medicating and has been taking his girlfriend's Olanzapine for many months as she doesn't take it. He estimates that he uses approximately 10 - 20mg a day. He claims that since stopping it he is experiencing distressing auditory and visual hallucinations, his mother screaming at his dad and when he closes his eyes he can see photo negatives of people. He told me that he has been admitted to a psychiatric hospital on numerous occasions and may have a diagnosis of schizophrenia. He was under a doctor. He lives with his girlfriend. He is on a charge of ABH but was put into custody due to breach of bail conditions.

“On mental state, he presents as unshaven and is visibly tremulous. He was slightly agitated and appeared to be

in a state of withdrawal. He immediately complained that he was hearing voices and needs more medication. There was a limited rapport but he remained cooperative and was non-threatening. His speech was increased in rate and volume. He appeared anxious in mood and described feeling low. He was pre-occupied by his hallucinatory experiences and though he said he felt suicidal he was quite suggestible and couldn't tell me of any specific plans to harm himself. He denied any homicidal urges. He had no abnormal thoughts but described hearing his mother screaming but could not make out specific words and visual disturbances as described above. Cognitive function was intact.

“He certainly presents with symptoms of alcohol withdrawal and it is difficult to ascertain whether he has underlying symptoms of mental illness whilst in this state. I have prescribed a small dose of Olanzapine due to his level of distress. I will request some collateral from the psychiatric hospital and in the meantime he should remain on healthcare.”

Mental health review by a psychiatrist

37. On 16 November, the man underwent a further mental health review, this time by another psychiatrist, who made the following entry in his medical record:

“I saw the man on the Healthcare Unit. He was admitted on 11 November. He was initially referred by the detox team as he was complaining of both auditory hallucinations as well as visual hallucinations. He was initially on A wing and was undergoing an alcohol detox.

“He stated that he began experiencing these unusual disturbances on arriving at Pentonville prison over one week ago. He has both second and third person auditory hallucinations he hears in the external space. They can also be commanding in nature. However, he is adamant that these commands are not in any way dangerous to himself or others. He also describes some unusual visual hallucinations of barking dogs and other images he finds very uncomfortable. He describes these visual hallucinations as being photo negatives on closing his eyes. They mostly only come on whilst he is in his cell by himself trying to go to sleep.

“He also complained of feeling quite low with fleeting suicidal thoughts. These suicidal thoughts are in the

form of wanting to hang himself. Again, he said he looks around the cell room for places to hang himself from.

“He has a long history of alcohol dependence and mental and behavioural disorder secondary to alcohol abuse. He was last admitted and discharged in September 2007 from the psychiatric hospital. He has in the past had several admissions for similar reasons. This particular admission only lasted a couple of days and was in the context of an argument he had with his girlfriend.

“His current offence is breach of bail. However, he has been convicted of ABH against his girlfriend who he says is now back with him. This particular breach of bail incident was when he visited his girlfriend after the assault, saying that they have now sorted things out and are back together. It is important to note that in the past he has also had an order to stay away from his parents due to harassment.

“Past psychiatric history: As already mentioned, he has been admitted on several occasions for short periods of time with a diagnosis of mental and behavioural disturbance secondary to alcohol. He has also five years ago taken a serious overdose. However, he does admit to fleeting suicidal thoughts even since then. Although he was prescribed anti-depressant medication a few years ago, he is not prescribed any medication currently apart from 10mg Diazepam from his GP. He does however say that he takes his girlfriend’s Olanzapine approximately 20mg-30mg a daily. He also said that he takes venlafaxine (again his girlfriend’s medication). I informed him of the dangers of taking medication that was not prescribed for him. He has also experienced delirium tremens on numerous occasions. He currently drinks 6-8 cans of strong cider per day, saying that this is quite low for him as he normally also drinks vodka.

“Current social history: He said he is staying with a friend in Southend. However, one of the reasons for his breach of bail conditions was that he visited his GP in Harrow on the Hill. He receives benefits. He has been unemployed for the last six years. He has been drinking heavily for the past ten years. He also admitted to snorting 1g of amphetamines 3-4 times per week.

“Mental State Examination: Appearance and behaviour. Anxious, reasonably well-kempt Caucasian man who looked older than his years. He provided good eye contact and was pleasant and appropriate throughout the

assessment. There were no unusual gestures or movements. He was not tremulous. He was not tearful or agitated. He was not obviously responding to any perceptual abnormalities. Speech: Normal in rate, rhythm and volume. Spontaneous and coherent.

“Mood: Subjectively ‘low’ objectively anxious with a reactive affect. He did complain of poor sleep over the past five days. He says he has been unable to sleep at all because of the perceptual abnormalities he has been experiencing. His appetite has been good. He said he has always had problems with his concentration but denies any problems with his energy levels. He said that he has fleeting thoughts of wanting to harm himself, in particular looking for places where he can hang himself from. However, there does not seem to be any real intent as he also says that he has plans for the future in terms of getting back with his girlfriend and sorting out his life. I did not feel that there were any negative cognitions.

“Thoughts: No formal thought disorder. No thought interference or passivity phenomena. He was preoccupied with his sleep and constantly asked me to prescribe him a higher dose of olanzapine. He spoke in detail how he would self-medicate. Eventually, he calmed down when I offered him zopiclone for the next three nights in the evenings. I feel it is important to note that in the previous discharge summary it was stated in a past psychiatric history that he has said “if you don’t admit me I will kill myself”.

“Perceptions: as already mentioned, he has been experiencing second and third person auditory hallucinations. These seem to be derogatory in nature, which are mainly of his mother screaming at him. However, he also describes his mother speaking to his father about him. He also experiences occasional command hallucinations, but not dangerous to himself or to others. He also described visual hallucinations which may be more pseudo-hallucinations. On closing his eyes, he sees quite uncomfortable images of animals in the photo negative detail. There are no tactile hallucinations.

“Cognition: He was oriented in time, place and person. However, a full mini mental state examination was not undertaken.

“Insight: He seems to have very good insight into his illness. He realises that these perceptual abnormalities are not real and it seems as though it has already been discussed with him that these are secondary to his long term alcohol abuse.

“Impression: A 34 year old gentleman with a long history of alcohol dependence syndrome. He has undergone alcohol detox for the past ten days, but is currently taking Olanzapine 5mg b.d. He does have a history of DTs and these perceptual abnormalities are not unusual. He says that he experiences these every now and then and requires admission. His main complaint at the moment is of a lack of sleep, and I felt that his mental state will improve once he has a few nights of restful sleep on the healthcare unit.

“Plan:

1. To remain on healthcare until Monday 19 November when I will review him.
2. I will prescribe three days' worth of zopiclone (to assist sleep).
3. To continue with Olanzapine 5mg twice daily.
4. To consider starting an ACCT for the short term once he is fit for transfer to ordinary location.”

38. The man was discharged from the healthcare centre on 19 November with no documented review but was reviewed four days later by the psychiatrist, who noted that he was in a state of anxiety and ‘withdrawal’. The psychiatrist prescribed a five day course of Diazepam.
39. The man presented in a state of anxiety and withdrawal on 23 November. He told the doctor his mood was low and he was experiencing thoughts of self-harm. The psychiatrist prescribed a five day course of Diazepam. There is no evidence that the option of opening an ACCT form was considered.
40. On 27 November, the man told the duty doctor that he had collapsed. It was found that he had suffered a bout of diarrhoea and vomiting. He asked the doctor to prescribe Diazepam. An appointment was made for him to consult a doctor the following morning but he did not attend.

December

41. On 1 December 2007, staff suspected that another prisoner had passed the man illicit drugs. The investigation found no evidence to show what action was taken by staff.

42. Four days later, the man complained that he was suffering from anxiety. He was assessed by a doctor, who diagnosed benzodiazapine dependency in view of his recent history and because of his use of prescribed and non-prescribed of drugs in the community. The doctor raised the issue of persistent unconfirmed drug use whilst in custody but did not document this. The doctor prescribed Diazepam 5 mg twice daily. He reviewed him on three further occasions in December in relation to his drug dependency and on one further occasion after the episode of self-harm described below.

ACCT form opened

43. On 20 December, after the man had made a superficial cut to his arm in his cell, an ACCT form was opened. This is a document used by all grades of staff to monitor those prisoners considered to pose a risk of self-harm or suicide and to assist him to reduce that risk. Whenever an ACCT form is opened, staff are required to undertake the following tasks:

- Complete a Concern and Keep Safe form

44. This form is designed to assist staff to identify the main reasons why the prisoner has become at risk of self-harm or suicide. The man's form was completed by an officer at 1.45pm on 20 December. He recorded the following information:

“He is not aware of self-harm due to the panicking behaviour. He is panicking and has a strong shaking behaviour. At the moment he is very slow in walking and talking. This caused by fear of being locked up in a cell. He is worried about his family and self whereabouts.”

- Draw up an immediate action plan

45. The function of the immediate action plan is to record the most appropriate environment and regime required to support the at-risk prisoner prior to the first case review. Prison Service Order 2700 sets out the requirement that the plan should be drawn up within one hour of the Concern and Keep Safe form being raised. The form was not completed until 5.20pm on 20 December, three hours beyond the required time limit.

The man's plan is shown in the following table:

Immediate action required	Action	By whom	Completed
Location	To remain in shared cell	By staff	Existing
Frequency of staff support	Hourly obs.	By staff	Ongoing
Phone access	Given phone call to family	By staff	20 Dec 07
Listener access	He is aware of Listener scheme and staff support.		Ongoing

Other immediate interventions	To be referred for mental health assessment and day care classes.	Staff	
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- Complete an assessment interview

46. This interview should also take place within 24 hours of the initial concern being raised. The aims of the assessment are:
- to draw out the prisoner's perceptions of the problems related to his current distress
 - to measure his mental state and his current suicidal thoughts and intentions
 - to identify what coping mechanisms can be utilised to help him manage and reduce his risk.

47. The man's assessment interview was conducted by an officer at 4.20pm on 21 December, approximately three hours beyond the time limit set out in Prison Service Order 2700. The officer wrote as follows:

"The man suffers from severe panic attacks and during one of these he made cuts to his arms. He says he has no real issues that would cause him to harm himself. He just can't help it at times. He has self-harmed before because of the same issues. He has no control over his actions. He also mentioned his mental health issues that might need to be addressed. He does take regular medication. He stated he has no intentions of suicide but he could he could not state whether he would cut again during a panic attack. He says he is close to his mum and dad and that he has regular visits from them. At present an officer has allowed him to help out with the cleaners. He says he is very happy on C wing. He should continue to help cleaners when possible."

- Undertake a first case review

48. The purpose of this review is to assess the immediate level of risk. The case review should bring together a multi-disciplinary team in order to consider the needs of the individual and the care required. The first case review should take place within 24 hours of the initial concerns being raised.
49. The man's first case review was conducted at 4.35pm on 21 December, approximately three hours beyond the required time limit set out in Prison Service Order 2700. The review took place in an office on C2 landing. The review panel comprised a senior officer and an officer. The man was present.
50. The review was summarised as follows:

“Only hurts himself when having a panic attack to take his mind off it. He has been offered a job assisting the cleaners. He is feeling much better now. He says he likes to keep busy. He is looking forward to getting a visit from his parents. An officer offered to assist him in booking his visits should he have any difficulty.”

51. The panel considered that the man’s risk of further self-harm was low and made a routine referral for a mental health assessment to be conducted. The next case review was scheduled for 24 December. A note made at the front of the ACCT form shows that he was to be subject to “one hour obs”. However, it is not clear from the record whether this entry refers to this case review.

- Draw up a Care and Management Plan (Care Map)

52. The purpose of the Care Map is to identify what actions can be taken to disable any suicide plan, to link the at-risk prisoner to people who can provide support, to build on any strengths or interests the prisoner may have and to encourage alternatives to self-injury. The Care Map should be drawn up at the first case review. The man’s Care Map was drawn up by a senior officer.

53. The following table shows the details of the Care Map:

Issues	Goals	Action required	By whom and when	Status of action
Gets bored	To keep busy or work	Assist cleaners - voluntary	An officer	Ongoing, began 21 Dec 07
Visits-wants regular contact with his family	Get visits	Send out visiting orders; telephone family; to book – an officer to assist	The man and an officer	Ongoing
Wants to get education	Education classes	Apply for education	The man	Started education English classes ongoing 25 January 08
Concerns over court case	To contact solicitors	To be allowed an office call to his solicitors on Monday 28 January 2008	Staff/the man	

Second ACCT case review

54. The next case review took place as planned at 3.00pm on 24 December, again in the office on C2 landing. On this occasion the review panel comprised a senior officer and an officer. No member of the healthcare team was present. The review was summarised thus:

“The man states that he feels very low at present. He feels a great pressure building inside his head and does not really know how to express himself at present. He feels that this was the cause of his previous act of self-harm. He states that he still feels this way. He also has not yet received a visit from his parents with whom he is in contact. He has concerns that his level of medication, recently increased, will soon be decreased. Showing signs of anxiety and distress. Aware of staff/Listener support. Given phone call to family. Observation level to increase to 2 hourly interventions.”

A note made at the front of the ACCT form shows that he was to be subject to “2 hourly obs”. However, it is not clear from the record whether this entry refers to this particular case review.

55. The panel considered that his risk of further self-harm was raised. The next case review was scheduled for 1 January. The case review record contains no reference to the objectives set in the care map.

January 2008

Third ACCT case review

56. The man’s third review took place on 2 January 2008, a day later than planned. A senior officer chaired the review and an officer attended. The man was present. The senior officer recorded the following summary:

“He is feeling more occupied now he is working as a wing cleaner and likes keeping busy during the day. He said his medication has again been reduced by half which he is finding very difficult to cope with. He is to see the doctor on Friday about this but would like sooner if possible. He finds night time the hardest period. Has not harmed himself but has had thoughts of self-harm which he has, with help of cell mate, talked himself out of. Observations lowered during the day but remain 2 hourly at night until medication review.”

57. The panel considered his risk of further self-harm remained raised and set the next review for 12 January.

Contact with Counselling, Assessment, Referral, Advice and Throughcare service (CARATs)

58. On 3 January the man had an appointment with a CARATs worker. The purpose of the appointment was to assess what level of support he needed both in prison and in the community to reduce his substance misuse.
59. He agreed the following care plan with his CARATs worker:

Objective	Method of measuring progress	Work to be done	By whom	When	Comments on completion
Provide support in prison and in the community. Offer further treatment and advice upon release.	Liaise with Drug Intervention Programme (DIP).	Refer direct to DIP team	CARATs, client and DIP team	Immediate	Referral made
Develop client's awareness of the risks of alcohol abuse. Learn coping skills, relapse prevention and harm minimisation.	Liaise with client.	Refer client to alcohol group.	CARATs and client	Immediate	Referral made

60. The CARATs worker summarised the man's main issues and key achievements prior to release as follows:

“He has used a variety of drugs during his lifetime. These include amphetamines, methadone, heroin, crack and cannabis. At present, in the community, he uses amphetamines as well as drinking heavily on a daily basis. He drinks on average 10 cans of strong cider a day. He stated that he started drinking at these levels at the age of 23. He stated that he previously attended AA meetings in the community for six weeks and was sober during this period. He also attended the James Cook House, Barking in 2000. “

Further mental health review

61. On 10 January 2008, the man underwent a further mental health review by the psychiatrist, who made the following record in his medical file:

“I have reviewed the consultations below and admit that I was unaware of his benzodiazepine dependence. The man told me that he would use other people’s prescriptions and never had an actual prescription of his own for valium on the out. He also used his girlfriend’s prescription for Venlafaxine (for treatment of depression) and was never actually prescribed it by his own GP. Initially during the assessment, he began requesting sleeping tablets and even warned me not to reduce his valium. His sleep has been much the same since I last saw him on the Healthcare Unit. He mainly complains of initial insomnia with broken sleep throughout the night. There does not seem to be any early morning waking, although he does not feel he has a restful night. He does participate in education on a daily basis and said he enjoys studying maths and English. He said he is particularly good at maths. He is also speaking to his girlfriend on a regular basis, who is currently living in his own flat.

“Although he said that he felt low, this seems to be more of a fleeting mood throughout the day. He finds he is at his lowest during the evening when locked in his cell. He even told me that he understood that partly the reason was that he was in prison. He said that he did not feel as bad during the daytime. However, he did want to discuss antidepressant medication with me and said that in the past he has been on zispin (mirtazapine) and that he was at his best when he was taking zispin which was whilst he was in Pentonville Prison.

“Regarding the self-harm incident two weeks ago, he said that he had not planned to harm himself during the day and it was only during the evening when he became extremely frustrated and angry at himself. He went on to say that he felt like banging his head on the walls but did not call for help from the officers. He then proceeded to cut his left forearm ‘close to the veins’ with the intent to kill himself. He said that he was quite frightened once he had done the act and then added that it was more of a cry for help “like my other attempts”. He was happy that the wound had healed quickly and did not have any more thoughts of DSH (deliberate self-harm)/suicide.

“There were certainly no psychotic symptoms elicited during this assessment and he was happy continuing taking Olanzapine 10mg by night. He is also currently on

5mg valium in the morning plus 10mg of Valium in the evening. This is a reducing regime looked over by his GP...

"...I went on to give him advice on sleep hygiene. Although I reassured him regarding his daily attendance to education, I asked him to increase his activity during the daytime.

"I do not feel like he has a major depressive illness at present. For this reason I do not feel he warrants any anti depressant medication on the basis of this assessment. I had not made any changes to his prescription chart. He does appear quite stable currently and was happy with the consultation.

"Plan: Review again in 4 – 6 weeks."

62. A doctor reviewed the man on two further occasions in January about his benzodiazepine prescription but did not make any entries in the ACCT form. On 18 January, the psychiatrist reviewed him as a result of an urgent referral because of his increased agitation. On this occasion, he prescribed a three day course of Zopiclone and made a corresponding entry in his ACCT ongoing record. On the same day, his CARATs worker made a note of the fact that his client was now engaged in maths and English classes and "had no further concerns".

Fourth ACCT case review

63. The man underwent a fourth ACCT case review as planned at 11.10am on 12 January. A senior officer chaired the review with an officer and the man present. No member of the healthcare team was present. The review took place in the office on C4 landing. It was summarised as follows:

"He stated he has had his medication issues addressed and feels much better. He is happy with his current cell mate but still requires support from landing staff. Due to this we have decided to leave him on his current observations for 2 weeks."

Fifth ACCT case review

64. The man's fifth ACCT case review took place on 25 January. The review panel comprised a senior officer and an officer. He also attended. Once again, no member of the healthcare team was present. The senior officer summarised the review thus:

"Says he feels low and likes the support of staff and the ACCT process. Gets on well with his cell mate. Says he

is not going to hurt himself. Says he does not want ACCT closed. Offered phone call to Sols ref court case on 18 February which he declined. Says he is not going to kill or harm himself. He insists he feels low but well. He knows how to get help if needed.”

65. The panel judged that his risk of further self-harm was low. A further review was set for 7 February. It is not clear what level of observation was set.

February

Application for enhanced level of privileges

66. The man applied for enhanced status under the Incentives and Earned Privileges (IEP) scheme on 6 February. This scheme is in place in all prisons and is designed to reward good behaviour with increased privileges. Those on the enhanced level are normally given extra visits, letters and telephone calls. He wrote on his application form,

“I’ve been here for three months now and I get on well with all the staff. I show courtesy to them. I comply with the wing regime. I’m in full time education and am getting on very well there too.”

67. In response, his landing officer wrote that the man had been on C wing for some time and was polite to staff and other prisoners. The officer felt that he deserved enhanced privilege status. His record does not clarify whether his application was approved.
68. The following day, he failed to appear for a review by a psychiatrist from the mental health team.

Sixth ACCT case review - ACCT closed

69. The man’s sixth ACCT case review took place as planned on 7 February. The review was chaired by a senior officer. An officer and the man were present. However, no member of the healthcare team was present.

70. The case review was summarised as follows:

“He is now attending full time education. He is bright and cheerful in demeanour with relevant eye contact throughout the interview. He is much happier and settled. He is now on a maintenance script with his medication. He states he has no intention of self-harm or suicide and that if he has a change of mood/situation he will approach staff. He is aware of all support services available. ACCT document closed.”

71. Whenever an ACCT document is closed, a post closure review must take place after an appropriate interval. The senior officer set 14 February as the date for the man's post closure review.

Further act of self-harm - ACCT re-opened

72. Two days after the man's ACCT form was closed, he made minor cuts to his left arm. Consequently, his original ACCT document was re-opened. A nurse examined him at midday in the C wing treatment room and applied six sutures.
73. The following information was recorded on the Concern and Keep Safe form by an officer:

“The man made a cut to his left lower arm using a razor blade. He did this during the serving of lunch whilst staff were on his landing. He said he felt he could not handle it but would not say what he could not handle. He said he has not been sleeping. He has previously been on an open ACCT only being closed recently (2 days).”

74. The Immediate Action Plan was as shown in the following table:

Concern about cell sharing?	No		
Immediate action required	Action	By whom	Completed
Location	Already in double cell. Happy with cell mate	Staff	9.2.08
Frequency of staff support	Every 2 hours until assessment	Staff	Ongoing
Phone access	As per regime	Prisoner/staff	Ongoing
Listener access	Explained and understood	Prisoner/staff	Ongoing

75. As the original ACCT form had been re-opened, no new care map was drawn up and no initial case review was conducted. My investigator was presented with no evidence to show that any subsequent case reviews were held. The front cover of the ACCT form indicated that it was closed again on 14 February. My investigator was told that this date was likely to have been the date of the planned ACCT post-closure review rather than to date the form was closed. Numerous entries were made in the ACCT ongoing record up to and including 23 February. The last entry was made on that day at 6.00pm. It said, “Management check. Obs noted.” My investigator was unable to ascertain whether or when this ACCT form was closed.
76. The entries made in the ACCT ongoing record between 9 and 23 February show that the man's mood and behaviour varied. Some of the more pertinent entries are repeated below.

2.35pm on 9 February:

“Prisoner has again self-harmed by cutting his left lower arm. He has just received his canteen and got his tobacco. This time he says he wants to go to D wing. Taken to see nurse in B/G wing treatments.”

2.50pm on 9 February

“Has been seen by Dr in reception who has prescribed him for more sleeping tablets. He also said that he is happy on C wing and does not wish to move. Thanked me for taking him to the doctors.”

4.00pm on 10 February

“His cell mate has been moved out due to the man self-harming constantly. We have given him a chance to find a cell mate of his choice but up till now no one wanted to be located with him due to his self-harming.”

3.15pm on 11 February

“He told me that he was feeling particularly bad and that he really felt like killing himself. He said he has suffered depression for years but has never felt this bad. He is unable to sleep at night and this is making him feel worse. I took him to see a MH doctor at healthcare who is going to adjust his medication to help him sleep.”

77. A doctor assessed the man on this occasion and prescribed a five day course of Zopiclone and arranged to review him again three weeks later. The doctor did not make a corresponding entry in the ACCT form. His CARATs file shows that he attended an alcohol group on 11 February.

Suspected overdose - admitted to hospital

78. At 4.00pm the next day, the following subjective comment was made in the ACCT ongoing record:

“He pretended to feel faint. Then when he saw medical staff he decided to be sick by sticking two fingers down his throat. He threw up in the bin next to the medical hatch on the wing....”

79. The man was examined by a nurse. He appeared to her to be passing “coffee ground vomit” and to be disorientated. Other prisoners reported that he may have been taking illicit drugs. There was also a suspicion that he may have bought medication from other prisoners in

exchange for tobacco. At 10.45pm, he was taken to hospital for observation. During his stay in the hospital, he was placed on constant observation. He became very aggressive towards the prison staff who were guarding him and had to be restrained in order to prevent him harming himself. At 9.00pm on 15 February, he was discharged from the hospital and admitted to the healthcare centre as soon as he arrived back at Pentonville.

Admission to healthcare centre

80. The following entry was made in his medical record:

“Admitted healthcare inpatient unit. For assessment of mental health. Admitted to HCC (healthcare centre) from reception after being discharged from hospital after a suspected overdose – unknown substance on 12 February. On speaking to him he denies taking any other than his prescribed medication, stating that he ‘felt funny’ after drinking large quantities of water. He says he doesn’t recall anything. Given hot water and zopiclone. Settled 23.30hrs and has slept through.”

Appearance in court and discharge from the healthcare centre

81. The man was taken to Crown Court during the afternoon of 21 February. The ACCT form accompanied him. The Prisoner Escort Record for the journey to and from court also noted that he was at risk of self-harm and indicated that he was vulnerable. He returned to the prison shortly before 6.00pm. An entry was made in his medical record indicating that he was fit to be discharged from the healthcare centre and to be placed in an ordinary wing on his return. His ACCT form contains no evidence that a case review prior to discharge from the healthcare centre was convened. No follow-up medical appointment was made.

Review by doctor

82. On 25 February, a doctor reviewed the man’s case after he had become agitated and anxious because he said he had not received any Diazepam for four days. The doctor prescribed a slowly reducing regime of Diazepam and arranged for a further review in due course.

83. The man’s CARATs worker recorded the following information in his CARATs file on 29 February:

“He stated he is feeling somewhat depressed at the moment. He stated that he has seen the doctor who is in the process of sorting out his medication. He stated that he does not want to do any group work at present. No further issues.”

March

84. A doctor reviewed the man again on 3 March and noted that he remained anxious.

New ACCT form opened

85. Shortly before midday on 12 March, the man's cell mate told an officer in D wing that he was crying. The officer spoke to him straightaway. He said he was going to hang himself because he did not want to live any more. The officer consulted a nurse in the wing treatments room with the aim of arranging an appointment for him to be seen by someone from the mental health team. He was told that no-one was available. However, the nurse arranged for the locum doctor to assess him that afternoon. The officer asked the cell mate to keep an eye on him during the lunch period. At about 12.45pm, the cell mate pressed his cell bell to alert staff to the fact that the man had made a rope and said he was going to hang himself. Both a doctor and a nurse assessed him straightaway. They decided to admit him to the healthcare centre and place him on constant observation. He remained subject to this level of observation until mid-morning the following day. Meanwhile, the officer decided to open a new ACCT form.

Concern and Keep Safe form

86. The officer completed the man's concern and keep safe form straight away. He told the officer he wanted to hang himself because he could not cope on the wing. The officer described him as nervous and shaking, with slow speech. He thought his mood was "quiet".

Immediate Action Plan

87. The man's immediate action plan was not drawn up until 7.45am on 13 March, some 18 hours beyond the required time limit set out in Prison Service Order 2700. The following table shows the plan's details:

Concern about cell sharing risk?	No		
Immediate action required	Action	By whom	Completed
Location	Admitted to healthcare centre by locum doctor for assessment. He is happy as this is what he wants.	Doctor	Done 12 March
Frequency of staff support	Initially on constant observation until review by MHT	Unit staff	Ongoing
Phone access	Has PIN number/credit	Unit staff	Done 12 March
Listener access	Aware of Listeners	Unit staff	Done 12 March

Other immediate interventions	Given TV	Unit staff	Done 12 March
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88. The plan also records that a case review was to be organised and a further assessment of the man was to be made. Healthcare staff were briefed about him and an entry was made in the unit staff observation book.

Assessment interview

89. The man's assessment interview was conducted by an officer in the healthcare centre at 3.15pm on 14 March over 48 hours after the initial concerns had been raised. It should have been completed within 24 hours of the initial concerns being raised. He told the officer he had once tried to hang himself and had also tried to jump in front of a car. He said he began to self-harm whilst in custody approximately four months earlier in order to "alleviate his issues". With regard to his physical state, the officer described him as "shambolic". He apparently looked ill and as if he had not been eating. The officer said he kept crying during the interview and could not stop shaking. He told the officer he was hearing voices and could not concentrate.
90. As far as the man's current mental state was concerned, the officer recorded that he told him he "wanted to end it all". He was fed up with living but gave no further information about how he might take his own life. He also said he had in the past made an attempt to overdose which resulted in his hospitalisation. However, when the officer asked him about what coping resources were available to him, he said he had a very supportive family and he had a flat.
91. The officer's concluding remarks in the record of the interview were that the man wished to see a doctor to discuss medication.

First case review

92. The man's first case review was held in the healthcare centre very shortly after his assessment interview. The case review panel comprised a senior officer, who is trained to work in support of healthcare staff, and a nurse. The man was also present.
93. The case review was summarised as follows:
- "He says he is feeling so depressed he says he cannot sleep and is having nightmares and anxiety attacks. He also says he is hearing voices (his mother). His mother doesn't tell him to self-harm but is very judgemental. He feels more settled and safer in the healthcare centre. He has been seen by the mental health team doctors but has not been prescribed any more meds. He has requested a phone call to his mother. I believe he is using the

ACCT as a manipulation tool to remain in the healthcare centre and manipulate his medication, even though his risk of self-harm is still real.

Observations: one hourly.”

94. The panel judged the man’s risk of further risk behaviour as “raised”. They decided he should be reviewed again one week later.

Care Map

95. The man’s care map was drawn up by a senior officer at the case review. The details are shown in the following table:

Issues	Goals	Action required	By whom and when	Status of action
Family contact	Phone call	Landing staff and Governor’s authority	Ongoing	
Ongoing MHT (Mental Health Team)	To keep in touch with MHT	MHT informed	Healthcare staff	Ongoing
To locate on C Wing with friends	Maintain support from friends	Relocate C4-02	Officer	20/21 March

Complaints of black-outs

96. The man was assessed by a doctor and a nurse manager during the lunch period on 13 March as he had complained of blackouts and trembling, which was thought to be due to benzodiazepine withdrawal. He made a full recovery. No drug screen was conducted. A doctor also assessed him as being depressed. Again no drug screen was performed and his medication was unchanged: he remained on Olanzapine 10mg once daily and Diazepam 7.5mg once daily.
97. On 18 March, the locum Trust doctor met the man for the first time. She documented that he was feeling low and was experiencing suicidal thoughts. This was in contrast to the views of other staff who reported in the ACCT document that he was sleeping and eating normally, was mixing with other patients and appeared to be “fine”. She did not make a corresponding entry in the ACCT form.

Court appearance

98. The man appeared at Crown Court on 19 March. He was convicted of his offence of Actual Bodily Harm and remanded in custody to appear for sentencing on 23 April.

Mental health review by psychiatrist and further ACCT case review

99. The locum doctor reviewed the man again on 20 March. Afterwards, she made the following entry in his medical record:

“He said that he is feeling very low/depressed and is not sleeping at all. It was discussed that he would be discharged from the healthcare wing today and will be reviewed in the clinic. He mentioned that if he was discharged he would hang himself. There has been no evidence of depressive symptoms during his period of stay here. He has been observed to have adequate biological functions.

“Discussed with doctors. Plan:

- To discharge him back to the wings from healthcare today
- To prioritise him going to a shared cell in view of the risk of him, trying to harm himself
- To have highest level of observation in the wing
- Clinic appointment end of next week for a doctor to review.”

100. He did not see a psychiatrist thereafter.

101. He underwent a further ACCT case review in the healthcare centre at 3.30pm the same day. The purpose of the review was to assess his readiness for discharge from the healthcare centre. The review panel comprised a principal officer and an officer. He was also present. The review was summarised as follows:

“Spoke about issues, talked about length of sentence and that he would be out in 5 weeks. He also stated that he couldn’t go to B Wing as he owed 6 pks of tobacco. Changed to C Wing and he was happy with that. Needs to keep in touch with MHT.”

102. His risk was considered to be raised. A Principal Officer (PO) told my investigator she made this judgement because she was aware that he was about to be transferred from the “nurturing environment” of a healthcare centre to a different environment in which the staffing level was lower. She decided that he should be observed hourly by day and night. She wrote the instruction on the front cover of the ACCT form so that it was clear to all staff. The next review was scheduled for 24 March. There is no evidence that the staff present at the review knew of the comments made by the locum doctor in his medical record about the need for him to have “the highest level of observation”.

103. The man was discharged from the healthcare centre on 21 March. No follow up appointment took place. He was allocated to a shared cell in C wing.

Further ACCT case review

104. The next case review took place as planned on 24 March at 10.30am in an office in C wing. This was attended by a senior officer, an officer and the man. No member of the healthcare team was present. The review was summarised as follows:

“Good eye contact and body posture. He states he is happier on C Wing – he knows people on the unit and is supported by the wing Listener. He gets on ok with his new cell mate and enjoys getting out onto the landings and mixing with others. He had a telephone call to his family yesterday that went well. However, he states he is still depressed which he puts down to being in prison. No new issues raised. Aware of all support networks available.”

105. His risk of further self-harm was assessed as low. It was decided that he should be observed once during the in the morning, once in the evening and every three hours by night. The next review was scheduled to take place on 4 April.
106. On 26 March, a doctor reviewed him regarding his Diazepam reduction. The doctor did not formally assess his mental state as he considered that he was under the care of the mental health team and would soon be assessed at a follow-up appointment. However, as another prisoner had died in the prison on 30 March, all those on an open ACCT form at the time were reviewed. This was in line with Prison Service policy. He was seen by a senior officer at 11.15am in the office on C2 landing.
107. The officer made the following record of the review:

“Following a death in custody this morning, the man was interviewed to see how he was. He said that it was the last thing he wanted to hear and it had upset him a lot due to his own suicidal tendencies and impulses. He is having more medication issues and I feel he is getting into debt with tobacco. He has asked for a phone call to his mother. Otherwise says he is okay and thanked me for our chat.”

108. The officer considered that his risk of further self-harm was “raised”. No record was made of the frequency of observations required.

April

Episode of hypotension

109. On 1 April, the man experienced an episode of hypotension (abnormally low blood pressure) and hypoxia (shortage of oxygen) in C wing. He was attended by a nurse, who referred him to the duty doctor. The doctor made a full assessment apart from a drug screen and, in view of his hypotension, sent him to the accident and emergency department at hospital. Here he was given fluids intravenously and blood tests were made. The results of these were normal. He was therefore discharged the same day.
110. The following day, he was transferred from C wing to D wing. The reasons for this move are not clear. That day, he was attended by a nurse after he had complained of shaking and feeling unwell. He asked to be given Diazepam. There is no evidence to show whether he was given any. His temperature and pulse were taken. These showed no abnormalities. He was reassured and he quickly settled thereafter.

Final ACCT case review

111. The man's last ACCT case review took place on 6 April. This time, the panel comprised of a senior officer and an officer. No member of the healthcare team attended. However, the man was present. The review was summarised thus:

“Spoke at length with him, who states he is ok and enjoys D Wing. Gets on well with cellmate and has no major concerns at present. Seems quite well balanced at the moment. However, I did say I would contact H/care for him to check on his psychiatric report for court.”

112. The panel considered that the man's risk of further self-harm was low. No record was made of the frequency of observations required. A further case review was scheduled for 14 April. The senior officer later told my investigator that during the review, he asked him when he was going to close the ACCT form because he was feeling fine. He said he was reluctant to close the form at that point because he wanted to gauge his behaviour over a longer period. He knew that the man had only just come onto the wing and he needed more time to settle. He therefore set a date for the next review to take place eight days later. He knew this was a Monday, when more staff could be involved in the review if that was necessary. He said he told him that he would consider closing the ACCT at that review if it was appropriate to do so.

Day of Incident

113. My investigator spoke to the man's cell mate about his knowledge of the man and about the events of the last day of his life. He said,

"I came to this prison on 26 January 2008. I think I met him towards the end of March. This was when I was in cell D4-31. He had been moved from C wing and he joined me in my cell. He said he had been having difficulties with his cell mate in C wing. He was therefore moved across to this wing. I'm not sure why he couldn't have been given another cell in C wing. He spent about three weeks with me before he died.

"On one occasion he went to court. He was returned to my cell the same day. He talked a lot about his court case. He had an outstanding charge of ABH. He pleaded guilty to the charge and was committed to the Crown Court. He had just completed an 18 month sentence. He was worried about having to do yet more time. He knew he would have to serve over 12 months. He was depressed about his court case but his biggest worry was his girlfriend. He would often call his parents in order to talk to her. He loved her very much and couldn't stop talking about her.

"He didn't seem to be withdrawing from alcohol but he used to tell me he couldn't wait to get out of prison so that he could have a drink. He had issues. I knew he was a self-harmer because I could see scars on his arms. He told me he had overdosed and had not long come from hospital. He said he had overdosed on the drugs he was taking. He said he had drunk too much water. He was sometimes hard to live with. He was always wanting something. You can only help so much. But he was a peaceful lad.

"He was treated well by staff. He didn't depend on them. He kept himself to himself. He never talked to me about wanting to kill himself. I thought that when he did harm himself he was crying out for help. He didn't want to be in prison but he couldn't control this. So he took it upon himself to harm himself. I had no reason to believe he was going to hang himself. It was only after he died that alarm bells began to ring in my mind. I began to blame myself. On the day he died, he kept asking me if I was going to education. When they called out for exercise at about 10.00am, I stayed in the cell with him. He was just lying on his bed, facing the wall. He was very quiet. He did ask me why I didn't go to education. I would not have known why he asked me that question.

“During the lunch time lock up, he asked me if I was going to education that afternoon. He wasn’t tearful. He was concerned his phone credit hadn’t been put on. I told him to wait until the afternoon. It might have been put on by then. He wanted to get hold of his mum so that he could speak to his girlfriend. He didn’t take his lunch meal.”

Telephone call

114. At 2.05pm, the man left his cell to telephone his girlfriend. A transcript of his telephone call was made available to my investigator. It revealed that his girlfriend thought he had been lying to her about the length of sentence he was likely to receive when his trial was completed. She was very angry and screamed at him several times during their conversation. She ended by telling him she did not love him.

115. The cellmate said to my investigator:

“At 2.00pm, we were unlocked for education. I was supposed to go but I stayed on the wing chatting to my mates on another landing. I saw him on the phone at the time. He seemed to be having an argument. He was distressed and talking loudly. I think he was talking to his mum.

“I noticed before I left the landing that the staff had already locked the cell door. They would have had to let him back in. I didn’t see him go back into his cell.”

116. An officer who was on duty on landing at the time told my investigator that the man’s cell door would have been unlocked to allow his cell mate to report for education. He said it was likely that the door remained open whilst he was making his telephone call and that he would have let himself back in the cell and shut the door afterwards. He said he seemed alright to him at the time. He acknowledged that he was likely to have been the last person to see him alive.

The man discovered hanging

117. A senior officer (SO) told my investigator that at approximately 3.40pm, he was talking to prisoners on D3 landing when two prisoners called to him to go to cell D4-31.

118. One of those prisoners, Prisoner A, told my investigator that another prisoner, Prisoner B, shouted to him and said he thought something was wrong in the man’s cell. He explained,

“...He asked me to see if the guy was ok. I said he’s always acting funny. Prisoner B said, ‘I don’t think he’s

alright'. He didn't say why he couldn't see inside the cell very well. When he shouted to me he was near the cell and I was very close to him but on the opposite side of the landing. In order to join him at the cell I had to go to the other end of the landing and back as there was no bridge across the landing at the end nearest the man's cell. It took me a matter of seconds to get to the cell. When I looked in the cell I saw him hanging. I shouted, 'Gov, gov' to the SO who was on the landing below. I used those words because I didn't want to alarm other prisoners."

119. The SO approached the cell and looked through the observation panel in the door. As he did so he saw the man hanging by a ligature from the window bars. He entered the cell and took his weight until two more officers, who were next to arrive, cut him down. The SO then raised a whistle alarm and shouted "fours" to indicate that help was needed on the fourth landing.
120. At the same time, an officer used his radio to summon help from the healthcare staff, indicating that this was a "level one", a code indicating a life threatening emergency. An ambulance was called at that point. Two officers administered cardio-pulmonary resuscitation (CPR) until two members of the healthcare team arrived and relieved them. The SO told my investigator that, despite the fact that fluids were discharged from the man's mouth, he continued to administer mouth to mouth resuscitation without having the benefit of a protective face mask.
121. Nurse A, who was in reception at the time, heard the whistle alarm. As he left to attend the emergency, the call was repeated as a level one emergency on D4 landing. He therefore asked Nurse B, who was also in reception, to accompany him. She agreed to go straight to D wing while he collected the emergency first aid bag. A defibrillator was not collected. (A defibrillator is a portable electronic device that automatically diagnoses potentially life threatening cardiac irregularities.) At this stage, neither knew that a prisoner had been found hanging. Nor did they know the exact cell in which the emergency had occurred. However, upon their arrival in D wing, they were directed to the cell by a governor.
122. Nurse B could see a group of officers outside the cell. An officer was recording staff movements in and out of the cell. She then saw the man on his back in the cell with his head adjacent to the door and his feet towards the cell window. CPR was in progress. An officer was administering chest compressions and the SO was applying mouth to mouth resuscitation.
123. Nurse B could find no signs of life. There was no pulse and no respiratory effort. She found that copious amounts of clear fluid were

draining from the man's mouth. There was evidence of cyanosis (ie the colour of his skin was grey/blue). She found no recordable blood pressure. His pupils were fixed and dilated. There was a ligature mark on the right side of his neck. As she assessed him, the SO told her what had happened. He wanted to apply two further chest compressions but she advised against this in view of the amount of fluids in his airway. She asked for the full level one emergency equipment, including the defibrillator, to be brought to the cell. Nurse A fetched the defibrillator from the healthcare centre. Meanwhile, she used an instrument to withdraw fluids from his mouth, inserted an airway and applied oxygen. The officer continued with chest compressions. Nurse A attached the defibrillator pads to his chest. At about 3.50pm, the defibrillator advised to shock. He delivered a shock but the rhythm analysis showed asystole (i.e. no cardiac electrical activity). Consequently, CPR was recommenced.

124. At this point, a doctor arrived and asked for the cell to be cleared of some furniture so that more space could be created. This was done. An attempt was made to insert a breathing tube but this was unsuccessful. Nurse B re-inserted a guedel airway (a device inserted to help clear a patient's airway) and applied further oxygen. CPR was continued throughout. The doctor attempted to insert a tube through which life saving drugs could be administered, but did not succeed. The man remained in asystole. At the doctor's request, adrenalin was administered at 4.00pm and again two minutes later. Paramedics arrived at that point and a full ambulance crew reached the cell six minutes later. At 4.09pm, the ambulance crew took over CPR and asked staff to clear the cell. Approximately one minute later, all staff except Nurse A and the ambulance crew left the cell. The paramedics intubated the man. The doctor remained outside the cell for about ten minutes. At about 4.22pm he entered the cell to discuss developments with the paramedics. At 4.25pm, an agreement was made to cease CPR. Death was pronounced at 4.26pm. No note was found in the cell.

125. The cellmate concluded his interview with my investigator as follows:

“When I found out that he had died I was shocked and distressed. I had been told that two prisoners saw him hanging and they alerted staff. I think they were probably looking for me. He wasn't sociable. He didn't have many friends. I believe he should not have been banged up on his own, especially because he was on an ACCT form.”

Informing the man's next of kin

126. Shortly after the man's death had been pronounced, another prisoner at Pentonville set fire to his cell in the segregation unit. The Governor and his staff therefore had to deal with that incident as well as with the aftermath of this death. As a result, the Governor asked the police to

inform the man's next of kin of his death. Essex police officers did so at his parents' house at 9.45pm, some five hours after his death.

Support to the family after the man's death

127. A letter of condolence from the Governor was sent to the man's family by courier at 2.00pm the next day. On that day, the Governor telephoned the family and offered to arrange for the prison's Family Liaison Officer to visit them.
128. The funeral took place on 22 April. The Family Liaison Officer attended on the Governor's behalf. The full costs of the funeral were offered to the family. The Governor extended to the man's father an invitation to visit the prison in order to view the cell in which his son died.
129. On 14 April, the man's parents were offered an opportunity to visit the prison so as to view their son's cell and talk to staff.

Support to prisoners and staff

Prisoners

130. The Governor also issued a Notice to Prisoners in which they too were informed of the man's death and offered support by Listeners, the chaplaincy, Independent Monitoring Board and any other member of staff. Arrangements were made to review all those for whom an ACCT form was currently open.

Staff

131. The staff involved when the man was discovered hanging and who attempted to save his life went to the treatment room on D2 landing in order to support each other. At 5.00pm, the Governor chaired a debrief of those staff.
132. The clinical review draws attention to the fact that there was no clinical debrief by appropriate healthcare managers.
133. On the same day, the Governor issued a Notice to Staff announcing the man's death and offering the support of the prison care team and the chaplaincy. He also announced that a critical debrief would be arranged.

ISSUES

134. Here I examine:

- Whether the man's health needs were adequately met while he was in custody.
- Whether his risk of self-harm or suicide was appropriately identified, monitored and managed.
- Whether the response when he was found hanging was prompt and effective.
- Whether appropriate courtesies and support were offered to the man's family in the aftermath of his death.

Were the man's health needs adequately met while he was in custody?

135. Here I rely heavily on the findings and conclusions reached by the clinical reviewer in her clinical review of the management of the man's health needs. It should be noted that her methodology included an overview of a document entitled, "Death in Custody Clinical Review: Interim Report: 27.2.1970 – 9.4.2008". This report was produced by a member of healthcare team at Pentonville.

136. The interim report by the member of the healthcare team and the clinical review by the clinical reviewer should be read in conjunction with my report. However, for ease of reference, the following table shows the recommendations made in the interim report together with corresponding comments from the clinical reviewer.

Referrals

Interim report findings	Comments by the clinical reviewer
<p>Recommendation 1.</p> <p>There should be a review of the referrals process to the Mental Health Team involving triage of urgent referrals. A clear auditable protocol of then system should be produced.</p>	<p>The investigation revealed an absence of a robust system for handling urgent referrals. This does not appear to have adversely affected the man's care.</p>

Drug testing

Interim review findings	Comments by the clinical reviewer
<p>Recommendation 2.</p> <p>There should be a written policy regarding drug testing for all psychiatric patients on admission to the healthcare unit which should be part of the initial nursing assessment. This should be</p>	<p>The man was known to have substance misuse problems. He was detoxified from heroin during a stay at Pentonville in August 2007 and there were several mentions of this in his subsequent medical records as well as a documented suspicion that he was</p>

<p>subject to regular audit,</p> <p>There should be an agreed policy for requesting healthcare performed drug screening on patients in HMP Pentonville where clinically indicated e.g. suspected withdrawal, unexplained collapse etc.</p>	<p>obtaining illicit drugs in prison which may have caused collapse and admission to hospital. However, he was not tested for illicit drugs at any time during his stay.</p> <p>This omission may have led to an incomplete or inaccurate diagnosis of his intercurrent physical and mental health problems during his stay and his clinical management may have been suboptimal as a result.</p>
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Induction of doctors

Interim review findings	Comments by the clinical reviewer
<p>Recommendation 3.</p> <p>The induction of new doctors should be should be reviewed. Consideration should be given to training relevant to working in a prison environment with its increased risk of self-harm and suicide and high levels of substance misuse. Induction should include formal ACCT training and appropriate training from the Substance Misuse team. The importance of thorough documentation should also be highlighted.</p>	<p>It appeared that the members of the psychiatric team who saw the man were either unaware of, or untrained in, the possible effects of his poly substance misuse. I did not find anything in the written medical record to suggest that medical staff lacked the skills to assess risk of self-harm or suicide. At least one junior doctor on the psychiatric had not been trained in ACCT procedures.</p>

Joint working

Interim review findings	Comments by the clinical reviewer
<p>Recommendation 4.</p> <p>There should be a review of joint working between primary care, secondary MHT care and the Substance Misuse service within HMP Pentonville. Monthly or twice monthly meetings to discuss shared patients would facilitate improved interdisciplinary communication and patient care.</p>	<p>Despite his previous history of poly substance misuse and suspicions of current misuse, the man was not assessed by the Substance Misuse Service during his stay. Joint working between the services would have facilitated improved diagnosis and management of his problems.</p>

Documentation of substance misuse

Interim review findings	Comments by the clinical reviewer
<p>Recommendation 5.</p> <p>Where there is a history of drug use within the prison this should be documented, especially as it may</p>	<p>The documentation of the man's previous drug misuse in his medical record was haphazard, although there was mention of it</p>

<p>provide important information for further consultations e.g. unexplained collapse/persistent hallucinatory symptoms.</p> <p>(The READ coding system enables staff who make entries in the electronic medical record to highlight a medical problem so that it is highly visible to the reader.)</p>	<p>in free text in a number of consultation entries made and it was fully READ coded during his previous stay in August 2007. Notably, the junior psychiatrist who saw him on 10 January 2008 for a mental health review documented that he had previously been unaware of his benzodiazepine dependence, even though he had seen him twice before.</p> <p>On 12 February 2008, a nurse documented that other prisoners said he had been buying medication from other prisoners, on which he may have overdosed, thus precipitating his admission to hospital. This does not appear to have been followed up or referenced prominently in his medical record.</p>
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Length of GP appointments

Interim review findings	Comments by the clinical reviewer
<p>Recommendation 6.</p> <p>Review of GP appointments should occur with regard to their time length and equivalence with that in the community. 10 minute consultations are considered usual practice and allow time for appropriate documentation.</p>	<p>GP clinics within Pentonville allow for 5-7 minute appointments. It would be extremely difficult to complete a consultation with a patient with complex problems in this time, particularly if the doctor had not seen then patient before. This short appointment time was noted to have compromised making the fullest possible entries in the man's medical record on occasion. In general practice in the community it would be considered good practice (and necessary) to offer such patients more than the standard 10 minute appointment if possible.</p>

Benzodiazepine policy

Interim review findings	Comments by the clinical reviewer
<p>Recommendation 7.</p> <p>The benzodiazepine policy produced in December 2007 by a Consultant, Substance Misuse Service, should be reviewed, agreed and implemented through clinical governance arrangements.</p>	<p>It was apparent that the management of the man's benzodiazepine dependence was suboptimal. There did not appear to be a clear management plan or schedule for the dose, or reduction in dosage of prescribed benzodiazepines, so it was difficult for the different doctors who saw him to manage his treatment consistently. There was evidence in his medical record that a too rapid dosage reduction had caused him significant distress at least once and could have had an ongoing impact on his mental state. All doctors working in the prison should be familiar with current Department of Health guidelines on the management of this condition and it is</p>

	hoped that any local policy is in line with these guidelines.
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ACCT documentation

Interim review findings	Comments by the clinical reviewer
<p>Recommendation 8.</p> <p>When patients are subject to an ACCT this must be clearly documented in the medical record using READ codes and including opening and closure dates. Systems should be in place to ensure that this occurs routinely and health care staff should make a brief entry into ACCT documents at the time of consultation.</p> <p>(The Electronic Medical Information System - EMIS - record can capture important information by entering a diagnosis or event by its code, known as READ code. Any READ code entry can then be highlighted as a problem.)</p>	<p>The documentation in the medical records of opening and closing ACCTs on the man was haphazard and would have made it more difficult for health care staff to know what level of risk of self-harm he was thought to be at any time.</p> <p>The opening of his first ACCT was recorded in his record on 20 December 2007 but not READ coded, so could not be highlighted as a problem.</p> <p>It is my impression that a second ACCT was opened early in 2008 but I cannot find any mention of this in his medical record.</p> <p>His third and last ACCT was opened on 12 March 2008, at which time he was considered a high risk of suicide and admitted to the healthcare unit. The intent to open his ACCT was written in his medical record but the act of opening the document was not READ coded and it was not clear in subsequent entries at what level of risk he was being managed.</p>

Good clinical care

Interim review findings	Comments by the clinical reviewer
<p>Recommendation 9.</p> <p>The panel would like to commend the actions of all those staff involved with the man's assessment and admission to the healthcare unit on 12 March 2008. The clinical care provided was safe and appropriate.</p>	<p>None.</p>

Supervision of psychiatric staff

Interim review findings	Comments by the clinical reviewer
<p data-bbox="336 320 794 353">Recommendation 10.</p> <p data-bbox="336 387 794 557">Supervision of junior staff should be reviewed so that it fulfils the guidance of the Royal College of Psychiatrists and is in line with the PCT's Mental Health Trust policy.</p>	<p data-bbox="802 387 1348 568">The psychiatrists in training were interviewed as part of the internal review of the man's death. The transcripts of these interviews revealed poor induction processes for new staff and inadequate supervision of their day to day work and their training.</p>

Follow-up post discharge of inpatients

Interim review findings	Comments by the clinical reviewer
<p data-bbox="336 728 794 761">Recommendation 11.</p> <p data-bbox="336 795 794 943">There should be a review of how follow-up appointments are made post inpatient discharge with a view to ensuring a robust system that is not single person dependent.</p>	<p data-bbox="802 795 1348 1003">Following discharge from his second and third inpatient stays in health care on 21 February and 21 March 2008 respectively, there was no arrangement for the man to have a follow-up appointment with the mental health team, despite the complexity of his case.</p>

Case load and allocation in the psychiatric team

Interim review findings	Comments by the clinical reviewer
<p data-bbox="336 1176 794 1209">Recommendation 12.</p> <p data-bbox="336 1243 794 1458">There should be some consideration of both doctor experience and complexity of patients' case when allocating patients' for both inpatient assessment and outpatient follow-up post health care admission.</p>	<p data-bbox="802 1243 1348 1545">Despite the complexity of his case, the man was never seen by a consultant psychiatrist during his five month stay at Pentonville, although a doctor's opinion was sought on one occasion by the Senior House Officer when the specialist registrar was unavailable in clinic on 20 March 2008. Apart from one entry in his record by the specialist registrar, all other entries were made by junior psychiatrists in training.</p>

137. The clinical reviewer makes the following additional comments:

Inadequate documentation in the medical record

“The EMIS medical record can capture important information by entering a diagnosis or event by its code, known as READ code. Any READ code entry can then be highlighted as a problem. These problems then appear as a problem list on the summary screen in the record and are a valuable means of highlighting important information, particularly to others using the record who may be unfamiliar with the patient. I have

already commented on the shortcomings in respect of adequate problem entries in relation to ACCT procedures. There are two other important examples of problems not being adequately documented.

“The man attempted self-harm on 20.12.2007 (cut to arm requiring stitching). He was seen by the GP but this self-harm was not documented in the record with a READ code and so was not registered as a problem. He also cut himself with a razor blade on 9.2.2008, requiring further stitching. There is no mention in the medical record at all on the day this occurred but it was noted by the junior psychiatrist two days subsequently. Again, it was not recorded as a problem with a READ code. It would therefore not be easily apparent from the medical record to others providing care that these episodes of self-harm had occurred.

“He was seen at hospital on two occasions following collapse – on 12.2.2008 (3 day admission) and 1.4.2008 (A and E assessment). These episodes were not READ coded in his medical record. It appears the cause of these collapses was not determined by the hospital although the collapse in February was strongly suspected by prison staff to be due to an overdose of illicitly obtained drugs. It is not recorded whether a referral letter was sent to the hospital with the patient on either of these occasions giving his medical history, which might have helped the hospital to reach a diagnosis. Another collapse on 27.11.2007 was managed without referral to hospital but again was not READ coded in the record. Neither was a cause postulated. It would therefore not be easily apparent from the medical record to others providing care that these episodes of collapse had occurred, nor what their cause was considered to be.

“I commend the use of a shared EMIS medical record between primary care and mental health. However, in the prison healthcare environment where many different healthcare professionals may be seeing the patient and making records, it is most important that the record is used to the best advantage.

“I recommend that all staff using the EMIS record should receive additional training in the use of READ codes and problem management.”

Management of the man's self-harm and suicide risk from time of discharge from and his inpatient Health Care on 20. 3 2008 and his death on 9.4.2008

“On discharge from Health Care on 20.3.2008 it was noted on the advice of the consultant psychiatrist that the man was to have ‘highest level of observation in the wing’ and a shared cell. He was supposed to have a clinic appointment at the end of the following week with the junior psychiatrist but there was no evidence that this appointment had been made or kept, as he did not see a psychiatrist again prior to his death.

“He was seen on 26 March and 2 April by the GP for review of his benzodiazepine dependence but there was no documentation of a mental state assessment. When questioned for the internal review, the GP said he did not formally assess his mental state as he considered he was under the care of the mental health team and would shortly be seen on a follow up appointment.

“His ACCT level of risk was reviewed after discharge from Health Care by prison officers on 24 March and considered to be low and his level of observations was reduced. At the next review on 30 March, it was considered raised but no mention made of any increase in the level of observations. At the last review on 6 April, three days before his death, his risk level was considered to be low, but again with no record of the level of observations.

”I endorse the recommendations made in the interim report arising from the prison health care internal review. Additionally, I recommend that all staff using the EMIS record receive additional training in the use of READ codes and problem management. Patients with a history of poly substance misuse present a particular challenge when being cared for in the prison setting. Recommendations 2, 3, 4, 5, 6 and 7 in the interim report should be taken very seriously in this context as his substance misuse problems could have been managed more appropriately.”

I endorse all the recommendations contained in the interim review and in the clinical review.

Was the man's risk of self-harm or suicide appropriately identified, monitored and managed?

Suicide warning form

138. When the man arrived initially at HMP Wormwood Scrubs on 6 November 2007, he was assessed as not being at risk of self-harm or suicide. However, when he was taken to court two days later, he told a Senior Prisoner Custody Officer (SPCO) that he would kill himself if he was not given the drugs he wanted. The SPCO raised a suicide warning form so as to alert any agency responsible for his care and safety to his risk of self-harm or suicide. Upon his arrival at HMP Pentonville after his court appearance, the warning form should have been seen and signed by a reception officer so that appropriate follow-up action could be taken. However, the form was not signed. The investigation found no evidence of any follow-up action in relation to the risk related information on the form.

The Governor should ensure that suicide/self-harm warning forms are always seen and signed during reception procedures and that appropriate follow up action is taken in relation to the risk information presented.

ACCT procedures

139. ACCT procedures were invoked for the man on the following three occasions at Pentonville.

- The first ACCT form was opened on 20 December after he had cut his arm. This form was closed on 7 February.
- The same form was re-opened on 9 February as a result of a similar act of self-harm. It is not clear whether or when this form was closed.
- A third and final ACCT form was opened on 12 March. This form remained in place until his death in April.

140. I comment below on the quality of the procedures followed during each of these three episodes.

First ACCT form

141. The man deliberately cut his arm on 20 December. His injury was not serious but a number of stitches were required. The investigation found evidence that the ACCT procedures followed during the currency of this ACCT form were broadly in line with national and local policy.

142. However, although a Concern and Keep Safe form was completed on time, the immediate action plan that followed it was completed marginally (three hours) outside the required time limit set down at paragraph 8 of Annex 8G in Prison Service Order 2700. The initial

assessment interview, too, was conducted outside the required time limit by the same margin as was the initial case review.

The Governor should remind his staff of the importance of adhering to the provisions of PSO 2700 where the timescales for the completion of immediate action plans, assessment interviews and initial case reviews are concerned. Appropriate training should be provided where necessary.

143. The record of the case review that took place on 24 December contained no references to the objectives set in the care map made out for the man three days earlier. In my view, there is little to be gained from drawing up a care map for an at risk prisoner if the objectives set in it are not reviewed and updated.

The Governor should remind his staff that care maps are an essential element of ACCT procedures and should be reviewed and updated at all case reviews.

144. In the 18 day period during which this form was in force, six case reviews were conducted. Comprehensive summaries were recorded at the end of each review. The man was present on each occasion. In my view, the decisions reached as to his risk were reasonable and the level of observations appropriate. Although regular entries were made in the ACCT ongoing record, it was, in some instances, difficult to discern what frequency of observations had been decided upon.

The Governor should ensure that clear and visible records are made in ACCT forms showing the frequency of observations decided upon at case reviews.

145. Although the records showed clear evidence of the presence of a case manager and a wing officer at each review, no other disciplines were represented at any of the reviews held in wings. The absence of a member of the health care team at any of the reviews was, in my view, a significant omission, especially in light of the fact that the man frequently expressed concerns about his medication. My investigator was given a copy of the local suicide and self-harm prevention policy which was in place prior to 1 April 2008 as well as a copy of the revised version that came into force after that date. In both documents, the requirement for healthcare staff to attend ACCT case reviews is clearly set out.
146. I am also concerned that, in some instances, doctors who reviewed the man at times when his ACCT was in force did not make any entries in the ACCT ongoing record for the information of those in the wings in which he was located. For example, the plan made by a doctor on 20 March was that, when he was discharged from the healthcare centre, he should receive the highest level of observation in the wing. This

was not recorded in the ACCT ongoing record for discipline staff to see and act upon.

The Governor should reinforce to wing and healthcare staff the requirement for ACCT case reviews to be conducted as a multi-disciplinary function, embracing the expertise of specialist staff such as the healthcare team, chaplaincy and others. This is especially important with prisoners like the man, who have current and historical substance misuse and mental health problems.

In order to promote effective communication between healthcare and wing staff with regard to important information about at risk prisoners, the PCT should ensure that doctors make appropriate entries in ACCT ongoing records as well as in clinical records.

147. The ACCT form was closed on 7 February. A post closure review was scheduled to take place a week later. However, the man cut his arm again on 9 February. As a result, the original ACCT form was re-opened.

Re-opened ACCT form

148. A new Concern and Keep Safe form was completed and a new Immediate Action Plan was drawn up on this occasion. However, the ACCT form contains no evidence that any case reviews took place. Neither does it show whether or when the form was closed. I consider that if it is the case that no reviews were held, there was a significant systemic failure. The seriousness of this apparent failure is mitigated by the fact that between 9 and 23 February, numerous entries were made in the ACCT ongoing record indicating that the man was observed at varying intervals wherever he was located. It is also mitigated by virtue of the fact that another ACCT form was opened on 12 March. However, I take the view that, in this case, either record keeping or the execution of ACCT procedures fell below acceptable standards.

The Governor should make sure that staff of all grades and disciplines are fully aware of the requirement for regular ACCT case reviews to be conducted and for proper records to be maintained. The Governor should ensure that appropriate training is provided where necessary.

ACCT form opened on 12 March

149. At 11.45am on 12 March, it came to the attention of staff that the man was crying in his cell and had threatened to hang himself. In response, an officer opened an ACCT form. Very soon afterwards, he was admitted to the healthcare centre.

150. A Concern and Keep Safe form was completed, an Immediate Action Plan was drawn up and an initial assessment interview was conducted. The fact that the man was admitted to the healthcare centre very quickly and was placed on a constant watch straightaway mitigates the delays that occurred in opening the ACCT form and in drawing up the Immediate Action Plan. However, once again the assessment interview did not take place within 24 hours of the initial concerns being raised. A Care Map was drawn up. One of the targets set in the plan was “to relocate him in C wing where he could be with friends”. Whilst I make no formal recommendation on this matter, I believe staff should be cautious about setting such a target so soon after his admission as an inpatient following his threat to hang himself.
151. At the first case review, held in the healthcare centre at 4.25pm on 14 March, a nurse and an SO trained and deployed to the unit in support of the healthcare team were present. A comprehensive summary of the review was recorded. The man said he felt more settled and safer in the healthcare centre. The panel thought he might have manipulated his admission but acknowledged that his risk of self-harm was nevertheless real. They judged his risk to be raised and decided that he should be observed once an hour.
152. Only one subsequent ACCT case review was conducted in the healthcare centre thereafter. This took place on 20 March. The purpose of the review to assess the man’s readiness for discharge to a wing. It was initially intended that he should go to B wing. However, when he disclosed that he was in debt to some prisoners there, it was decided that he should go to C wing instead. He told the panel he was happy with this. Nevertheless, despite his risk of further self-harm being considered to be raised, he was discharged.
153. I am concerned that the man was discharged from the healthcare centre at a time when his risk was judged to be raised. I make this comment in the context of the concerns expressed by the clinical reviewer in her clinical review on this issue. She draws attention to the fact that a psychiatrist who assessed him on 20 March considered that he required the highest level of observation after his discharge to a wing. The investigation found no evidence that this requirement was considered during the ACCT case review. I note that the case review summary does not contain any mention of the level of observations decided upon. Although a number of entries were made on the front cover of the ACCT form about observation levels, it is not easy to discern which, if any, refer to this particular case review. (That said, it is clear from the ACCT ongoing record that he was observed once hourly after being discharged.)
154. I question whether, if the man’s risk of self-harm or suicide was such as to require the “highest level of observation” in a wing, it was wise to discharge him from the healthcare centre. However, I note that the psychiatrist took the precaution of arranging for him to be assessed

again a week later. Had this happened, a better professional eye could have been kept on his state of mind. It is regrettable that no such follow-up assessment took place.

155. In her clinical review, the clinical reviewer comments on this matter as follows:

"In the context of a patient with complex substance misuse and personality problems who self-harms relatively frequently, it is difficult to know whether the man's death could have been prevented by closer monitoring and the appropriate psychiatric follow-up after discharge on 20 March. The NICE guidelines of July 2004 - 'Self Harm: The short term physical and psychological management and prevention of self harm in primary and secondary care' discuss in depth the difficulty of making a quantitative assessment of suicide risk in a person already recognised to be at increased risk, as he clearly was, due to previous self-harm attempts and other psychosocial factors. However, the ACCT procedure alone appeared too blunt a monitoring tool for a person with his problems.

"Recommendations 3, 8, 11 and 12 in the interim report merit particular attention in relation to this finding."

Should the man have been left alone in his cell on 9 April?

156. From the point of the man's discharge from the healthcare centre on 21 March, he was considered to require shared accommodation so as to minimise the possibility of self-harm or suicide. He spent time in B and C wings before finally transferring to D wing on 2 April. He was in a shared cell throughout.
157. The ACCT case review nearest to the date of his death took place on 6 April. The review summary shows that the panel thought he was well-balanced. He was getting on well with his cell mate and had no concerns. His risk of self-harm was considered to be low. He was alone in his cell in D wing from about 2.10pm on 9 April. He was found hanging at 3.40pm. Although his cell mate could hear him talking loudly whilst on the telephone as if he were having an argument, he did not see him return to his cell. An officer said he "seemed alright". Thus, he gave no obvious signs that he was actively contemplating suicide.
158. My experience of other investigations has shown how common it is for an at risk prisoner in a shared cell to wait for his cell mate to leave before taking his own life. Ideally, no prisoner on an open ACCT form should be left alone in his cell. The reality is that this cannot be

guaranteed. Staff are unable to require the cell mate of an at-risk prisoner to remain in the cell.

The Governor should ensure that prisoners on open ACCT forms who are deemed to require shared accommodation, are observed at frequent intervals in their cells during periods when their cell mate cannot be with them.

Was the response to the discovery of the man hanging prompt and effective?

159. The findings of the internal interim review, supported by the clinical reviewer, are as follows:

“Both discipline and healthcare staff should be commended for the attempted resuscitation of the man. Appropriate resuscitation, basic and advanced life support were carried out according to national resuscitation guidelines in a difficult physical environment. Discipline and healthcare staff worked effectively as a team and tasks were performed and handed over appropriately according to expertise.

“Recommendations

- Review availability of one way valve (protective face masks) for staff who might be involved in resuscitation procedures.
- For all Hotel 9 the exact location must be stated. If CPR is in progress, this information should be given as part of the level one call. Healthcare and the prison should review current policy around locked gates/wings and landing access during resuscitation.
- Following any attempted resuscitation, there should always be a short clinical debrief involving all the team members which should be documented in the medical records.”

(Hotel 9 is the radio call sign allocated to any member of the healthcare team assigned the responsibility for responding to a medical emergency. ‘Level one’ is the term used to describe a life threatening incident.)

160. I agree with the clinical reviewer’s conclusion. However, I believe the SO deserves particular credit for administering mouth-to-mouth resuscitation without a protective face mask regardless of any risk to his own health.

Were appropriate courtesies and support offered to the man's family in the aftermath of his death?

161. Shortly after the man's death, another prisoner set fire to his cell in the segregation unit at Pentonville. The Governor and his staff had therefore to deal with two major events simultaneously. Although it would have been more appropriate for a representative of the prison to inform his family of his death, I understand why the Governor chose to ask the police to undertake this task. The five hour delay in informing the family was, I understand, caused by the fact that two police forces became involved in managing the task. In the circumstances, this seemed unavoidable. Whilst I make no formal recommendation on this matter, I believe that the news of a prisoner's death should ideally be communicated to the next of kin by the Prison Service, rather than by the police, as soon as possible after death has been pronounced.
162. I am satisfied that appropriate support was offered to the family thereafter.

CONCLUSIONS

163. The investigation found a number of deficiencies in the quality of healthcare afforded to the man while he was in custody at HMP Pentonville. Although his alcohol dependency was treated, he was not tested for the use of illicit drugs at any time. The psychiatric team did not seem to be aware of the possible effects of his poly substance misuse and he was not assessed by the Substance Misuse Service. This omission may have led to an incomplete or inaccurate diagnosis of his physical and mental health problems.
164. So far as suicide prevention was concerned, the investigation found evidence that some of the ACCT procedures followed fell below acceptable standards. There were also occasions when the healthcare team was not represented at ACCT case reviews.
165. However, the manner in which staff and paramedics attempted to save the man's life is worthy of commendation, as are the actions of the SO who gave mouth to mouth resuscitation without the benefit of a protective face mask regardless of any risk to his own health.
166. A number of recommendations are made about these and other issues. It is essential that urgent action is taken to implement them.

RECOMMENDATIONS

Recommendations to the Governor

1. The Governor should ensure that suicide/self-harm warning forms are always seen and signed during reception procedures and that appropriate follow up action is taken in relation to the risk information presented.
2. The Governor should ensure that clear and visible records are made in ACCT forms showing the frequency of observations decided upon at case reviews.
3. The Governor should remind his staff of the importance of adhering to the provisions of PSO 2700 where the timescales for the completion of immediate action plans, assessment interviews and initial case reviews are concerned. Appropriate training should be provided where necessary.
4. The Governor should reinforce to discipline and healthcare staff the requirement for ACCT case reviews to be conducted as a multi-disciplinary function, embracing the expertise of specialist staff such as the healthcare team, chaplaincy and others. This is especially important in cases involving prisoners like the man who are at risk of self-harm or suicide and have current and historical substance misuse problems.
5. The Governor should make doubly sure that staff of all grades and disciplines are fully aware of the requirement for regular ACCT case reviews to be conducted and for proper records to be maintained. The Governor should ensure that appropriate training is provided where necessary.
6. The Governor should ensure that prisoners on open ACCT forms and deemed to require shared accommodation, are observed at frequent intervals in their cells during periods when their cell mate cannot be with them.

Recommendations to the Primary Care Trust

1. The PCT should consider implementing each recommendation listed in the internal review and supported by the clinical reviewer in her clinical review as well as those made by her herself.
2. In order to promote effective communication between healthcare and discipline staff with regard to important information about at risk prisoners, the PCT should ensure that doctors make appropriate entries in ACCT ongoing records as well as in clinical records.

Commendations

1. The SO should be commended for administering mouth to mouth resuscitation without a protective face mask regardless of any risk to his own health.

2. All those staff involved in the discovery of the man hanging and in attempting to save his life in very harrowing circumstances, should also be commended.